DELINEATION OF CLINICAL PRIVILEGES - PODIATRY
(For use of this form, see AR 40-68; the proponent agency is OTSG.)

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. FACILITY

INSTRUCTIONS:

PROVIDER: Enter the appropriate provider code in the column marked "REQUESTED". Each category and/or individual privilege listed must be coded. For procedures listed, <u>line through and initial</u> any criteria/applications that do not apply. Your signature is required at the end of Section I. Once approved, any revisions or corrections to this list of privileges will require you to submit a new DA Form 5440.

SUPERVISOR: Review each category and/or individual privilege coded by the provider and enter the appropriate approval code in the column marked "APPROVED". This serves as your recommendation to the commander who is the approval authority. Your overall recommendation and signature are required in Section II of this form.

PROVIDER CODES	APPROVAL CODES
1 - Fully competent to perform	1 - Approved as fully competent
2 - Modification requested *(Justification attached)*	2 - Modification required *(Justification noted)*
3 - Supervision requested	3 - Supervision required
4 - Not requested due to lack of expertise	4 - Not approved, insufficient expertise
5 - Not requested due to lack of facility support	5 - Not approved, insufficient facility support

SECTION I - CLINICAL PRIVILEGES

Category I.
Treat routine conditions of the foot and work under the supervision of a privileged podiatrist who assumes full responsibility of the provider's acts.

Requested	Approved	
		Category I clinical privileges

Category II. Includes Category I.
Examine, diagnose, and treat conditions of the feet requiring skills acquired during post-residency specialty training. Consultations should be used when there is doubt concerning the diagnosis or when there is evidence of systemic disease, as first manifested by pedal symptoms.

Requested	Approved	
		Category II clinical privileges

Category III. Includes Categories I and II.
Includes Categories I and II. Board certified or eligible. Prevention, diagnosis and treatment of complications involving the foot, arising from various systemic diseases, as well as the palliative and corrective treatment of local foot pathology.

Requested	Approved	
		Category III clinical privileges

AREAS OF FOOT PATHOLOGY

Requested	Approved		Requested	Approved	
		a. General Practice			d. Foot Orthopedics
		b. Foot Surgery			e. Podopediatrics
		(1) Common Podiatric Surgical Procedures *(Specify in list which follows)*			f. Podogeriatrics
		(2) Complex Reconstructive Surgery *(Specify in list which follows)*			g. X-Ray Services (Interpretation)
		c. Podiatric Dermatology			

COMMON PODIATRIC SURGICAL PROCEDURES

Requested	Approved	SKIN	Requested	Approved	NERVES
		a. Digital syndactylism			a. Decompression (posterior tibial nerve) tarsal tunnel
		b. Excision of cutaneous lesions, benign			b. Decompression sinus tarsi
		c. Excision of soft tissue lesions, cysts			c. Excision of neuroma
		d. Grafts (simple, rotational, pedicle flap)			
		e. Plastic revisions (forefoot)			**TENDONS**
		f. Removal of foreign body			a. Capsulotomy, midfoot with or without tendon lengthening
		g. Toenail procedures			
					b. Excision of cyst, (extra or intra-tendonous), foot
					c. Percutaneous Achilles lengthening

Requested	Approved	OTHER *(Continued)*	Requested	Approved	
		j. Microvascular procedure			n. Vertical talus release/reconstruction
		k. Repair of ruptured tendo-achilles			
		l. Suspected malignant neoplasms of the foot			
		m. Tendo-achilles, peroneus longus: Tendon lengthening			

COMMENTS

	SIGNATURE OF PROVIDER	DATE *(YYYYMMDD)*

SECTION II - SUPERVISOR'S RECOMMENDATION

Approval as requested ☐   Approval with Modifications *(Specify below)* ☐   Disapproval *(Specify below)* ☐

COMMENTS

DEPARTMENT/SERVICE CHIEF *(Typed name and title)*	SIGNATURE	DATE *(YYYYMMDD)*

SECTION III - CREDENTIALS COMMITTEE RECOMMENDATION

Approval as requested ☐   Approval with Modifications *(Specify below)* ☐   Disapproval *(Specify below)* ☐

COMMENTS

CREDENTIALS COMMITTEE CHAIRPERSON *(Name and rank)*	SIGNATURE	DATE *(YYYYMMDD)*